

## Consent for Treatment

\*\* If the patient is under the age of 18, these forms must be completed by a parent/guardian and all consents must be signed by a parent or guardian.

**About Physical Therapy Treatment:** The physical therapist or physical therapist assistant will use their hands or equipment to stimulate or move your muscles and joints and will ask you to assist in therapy by participating in exercises, both at the treatment facility and at home. During the evaluation, therapy, and exercises, you may feel some pain, pressure, and tenderness. In some cases, additional procedures may be recommended, such hot/cold packs or electric muscle stimulation.

**Possible Risks:** As with any health care procedure, there are risks involved in undertaking physical therapy. The risks of physical therapy include bone fracture, muscle strain, ligament sprain, dislocation of joints, or injury to discs, nerves or spinal cord. Many patients notice stiffness or soreness during and after treatment. The additional procedures can produce skin irritation, burns or minor complications.

**Risks of Remaining Untreated:** “Doing nothing” or delaying treatment may prevent the soreness of starting physical therapy, but it also has risks. It is possible that scar tissue or adhesions can form, or that degenerative changes can occur. Your muscles can get weaker from lack of use, for example. These changes can further reduce your mobility, set off chronic pain cycles, and make future rehabilitation more difficult.

\*\*\*\*\*  
\*\*\*\*\*

I have evaluated the risks and benefits of physical therapy, have freely decided to undergo the recommended treatment, and hereby give my full consent.

\_\_\_\_\_  
Patient Printed Name

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physical Therapist's Name

\_\_\_\_\_  
Physical Therapist's Signature

\_\_\_\_\_  
Date

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

SEX: \_\_\_\_\_ PREFERRED PRONOUN(S): \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ ST: \_\_\_\_\_ ZIP: \_\_\_\_\_ EMAIL: \_\_\_\_\_

HOME PH#: \_\_\_\_\_ WORK PH#: \_\_\_\_\_ CELL PH#: \_\_\_\_\_

EMERGENCY CONTACT NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOW DID YOU HEAR OF OUR FACILITY? \_\_\_\_\_

EMPLOYER/ SCHOOL NAME: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

REFERRING MD: \_\_\_\_\_

PRIMARY CARE PHYSICIAN: \_\_\_\_\_

***IS YOUR INJURY RELATED TO A MOTOR VEHICLE ACCIDENT OR EMPLOYMENT: Y or N***

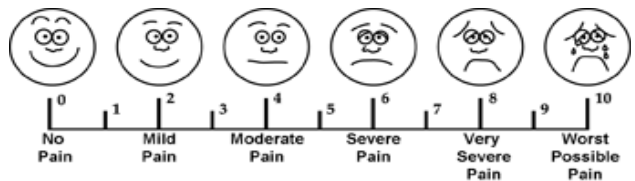
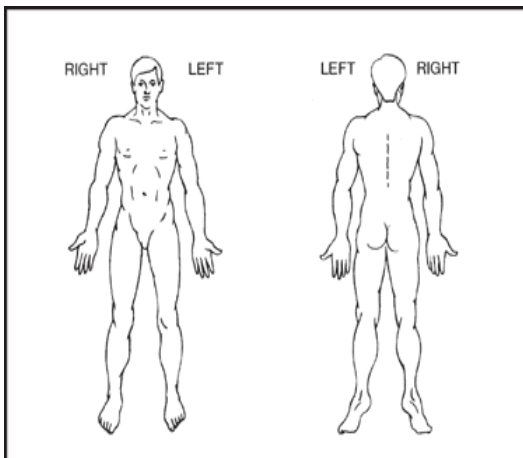
MVA OR WC INSURANCE COMPANY: \_\_\_\_\_

CLAIM NUMBER: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

ADJUSTOR'S NAME: \_\_\_\_\_ PH#: \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_ PH#: \_\_\_\_\_

**Please mark on the diagram below where you are experiencing any symptoms related to your injury:**



Using a 0-10 scale to rate your pain, with 0 equaling no pain and 10 equaling the most pain imaginable, answer the following questions:

In the past 48 hours, how would you rate your pain at worst? \_\_\_\_\_ /10

In the past 48 hours, how would you rate your pain at best? \_\_\_\_\_ /10

## MEDICAL & SOCIAL HISTORY INFORMATION

Please provide our physical therapists with as much personal medical information as possible. There is space provided at the bottom of this form for any additional information that you feel may be pertinent to your case. Best estimates are fine if you cannot remember specific details. If you are uncomfortable with any question, do not answer it.

Prior History/Current Conditions: (Please check all that apply):

<input type="checkbox"/>	High Blood Pressure (Hypertension)
<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Heart Attack/Heart Disease
<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	Lung/Respiratory Conditions (or Asthma)
<input type="checkbox"/>	Diabetes: (Specify type): _____
<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	Gastric-Intestinal Problems

<input type="checkbox"/>	Cancer: (Specify): _____
<input type="checkbox"/>	Prior fractures: (Specify): _____
<input type="checkbox"/>	Prior Neck and/or Back Condition
<input type="checkbox"/>	Arthritis: (Specify): _____
<input type="checkbox"/>	Allergies: (Specify type & reaction): _____
<input type="checkbox"/>	Prior ligament sprain/strain: (Specify): _____
<input type="checkbox"/>	Lupus

Do you smoke? \_\_\_\_\_ Have you ever smoked? \_\_\_\_\_ # of yrs \_\_\_\_\_ Quit date: \_\_\_\_\_

At this time are you taking any medication? Y or N. If yes, please list below.

\_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly? No \_\_\_\_\_ Yes \_\_\_\_\_

Any physician restrictions concerning exercise? Y or N? Please explain:

Please list below any conditions that may have required surgery in the past and the surgery dates.

Please check the following boxes if you are experiencing any of the following:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Unexplained weight loss          | <input type="checkbox"/> Persistent pain at night            | <input type="checkbox"/> Abdominal pain                   |
| <input type="checkbox"/> Unusual lumps/growths            | <input type="checkbox"/> Unwarranted fatigue                 | <input type="checkbox"/> Shortness of breath              |
| <input type="checkbox"/> Dizziness                        | <input type="checkbox"/> Pain or heaviness in chest          | <input type="checkbox"/> Frequent heart burn              |
| <input type="checkbox"/> Constant/Severe pain in the calf | <input type="checkbox"/> Sudden weakness                     | <input type="checkbox"/> Bladder/bowel changes            |
| <input type="checkbox"/> Fever or night sweats            | <input type="checkbox"/> Frequent nausea or vomiting         | <input type="checkbox"/> Recent Fall                      |
| <input type="checkbox"/> Severe headaches without cause   | <input type="checkbox"/> Recent severe emotional disturbance | <input type="checkbox"/> Balance or coordination problems |
| <input type="checkbox"/> Faint Spells                     | <input type="checkbox"/> Pregnancy                           |   |

## **MEDICAL & SOCIAL HISTORY INFORMATION (CONT.)**

Besides the injury that you are here for, is there currently any other medical ailment or condition for which you require treatment?: Y or N? Explain below:

Please list below any other medical information you would like us to know:

### **CURRENT CONDITION INFORMATION**

Briefly describe the current condition in which you are seeking care.

Most recent doctor visit? \_\_\_\_\_ Next doctor visit? \_\_\_\_\_ Surgery Date \_\_\_\_\_  
(if applicable)

Have you had any diagnostic imaging for this condition? (e.g., X-ray, MRI, etc...) If yes, please describe any known results.

Have you had any previous treatment for this condition? Y or N? (check all that apply.)

PT (Home/Outpatient)  OT (Home/Outpatient)  Massage  Bracing  Acupuncture  Chiropractor

How would you describe any pain you are experiencing? (check all that apply.)

Numb  Tingling  Dull  Deep  Superficial  Constant  Intermittent  Occasional

What activities are you having difficulty with? (example: driving, walking, sitting, lifting, working)

What are your goals for Physical Therapy?

What makes the injury worse?

What makes the injury better?

## **FINANCIAL POLICIES AND CONSENTS**

Please initial to the right of each policy below to acknowledge you have read and understand it. Then, sign and date at the bottom.

**PATIENT FINANCIAL POLICY :** It is the patient's responsibility to know what your health insurance company allows with regards to medical coverage and physical therapy benefits. If your insurance requires a referral for physical therapy, it is your responsibility to contact your primary care physician and ensure that a referral is processed prior to your first visit. All patient's co-pays are due at the time of service. If your insurance company does not pay the practice within a reasonable length of time, we will look to you for payment. If for any reason your insurance does not pay any portion of your bill, any balance due is your responsibility and payment is due upon receipt of a statement from our office.

It is the patient's responsibility to notify Beantown Physio, Inc. of any changes to insurance coverage or status prior to the changes taking effect. Many physical therapy services require prior-authorization and coverage cannot be backdated. It is the patient's responsibility to notify Beantown Physio, Inc., as well as the treating therapist, if an injury is related to a motor vehicle accident or employment.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical/workers compensation/motor vehicle insurance plan, to issue payment check(s) directly to Beantown Physio, Inc. for services rendered. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Beantown Physio, Inc. to: (1) release any information necessary to insurance carriers regarding my illness and treatments; and (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing.

\_\_\_\_\_  
Initial

**NOTICE OF CANCELLATION/ NO-SHOW POLICY:** Our office reserves the right to assess a \$35.00 fee to patients who do not cancel their scheduled appointment with at least 24-hour notice prior to the appointment. One courtesy cancellation will be granted to each patient. In the event of a snow or ice storm, the fee will be waived. Please understand that our time with you is valuable; if you cannot keep an appointment we appreciate the notice ahead of time so that your time slot may be filled by another deserving patient.

\_\_\_\_\_  
Initial

**HOME HEALTH/HOME PHYSICAL THERAPY WAIVER :** It is the patient's responsibility to inform the office, as well as their therapist, if they are currently receiving home health care/home physical therapy. If you are not currently receiving home health care/home physical therapy, it is your responsibility to inform Beantown Physio if you begin receiving home health care/home physical therapy at any point during your treatment. If services are denied by your insurance carrier for the reason of having home health care/home physical therapy, you will be responsible for all outstanding bills.

\_\_\_\_\_  
Initial

**PRIVACY PRACTICES ACKNOWLEDGEMENT:** I have received the Notice of Privacy Practices and have been given an opportunity to review it.

**TEACHING FACILITY ACKNOWLEDGEMENT:** Beantown Physio, Inc. is proud to be a clinical teaching institution to students from many colleges and universities. If a qualified physical therapy student at any times assists with your treatment, a licensed physical therapist will always supervise and monitor your program.

\_\_\_\_\_  
Initial

\_\_\_\_\_  
Initial

**I have read and understand the above referenced policies of Beantown Physio, Inc. and agree to be bound by their terms.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_